That’s the Way We Do Things Around Here!

Your Actions Speak Louder Than Words When It Comes To Patient Safety

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Medication Errors

Studies have long shown that an organization’s safety culture is the most critical, underlying predictor of accomplishments related to safety.1,4 A multitude of definitions of safety culture exist, but none is more telling than “that’s the way we do things around here.”6

An organization’s culture encompasses observable customs, behavioral norms, stories, and rites that occur in the organization, as well as the unobservable assumptions, values, beliefs, and ideas shared by groups within the organization. Culture is the most stable and significant force that shapes the way workers perceive the organization’s values and, in turn, how they think, behave, and approach their work.2,7 It is the organization’s safety culture that produces social concepts regarding what is considered dangerous or safe, and what attitudes and behaviors toward risk, danger, and safety are appropriate.8

A number of survey instruments have been developed3–11 and used in organizations to assess and measure the safety culture. These surveys evaluate typical features of a safety culture, such as leadership, staffing, communication, and reporting. The results of the surveys are often used to identify strengths and weaknesses in the current culture.

A recent study by Wakefield et al.5 has taken culture surveys a step further, going beyond merely measuring aspects of a safety culture to gaining an improved understanding of the factors that influence physicians, nurses, pharmacists, and other health professionals (e.g., respiratory/physical/occupational therapists) to engage in patient safety–related behaviors associated with high reliability (e.g., reporting hazards and errors, speaking out about risks, intervening when an error or at-risk behavior is witnessed, following safety guidelines).12

To conduct this study, a proven behavioral model was used to identify general factors that might influence the practitioner’s intent to engage in patient safety behaviors. Additional factors that might predict patient safety behavior were identified from the safety literature and focus groups. Based on these factors (Table 1), a survey instrument with 136 items was developed and administered to more than 5,000 physicians, nurses, pharmacists, and other health professionals in 37 hospitals located throughout Queensland, Australia.

The study found that the two strongest predictors of high-level patient safety behaviors for all health care workers are:

- Observed behaviors of professional peers (professional peer behavior)
- A genuine belief in the safety outcomes of the behaviors (preventive action beliefs)

When the different professional groups were compared, medical residents (referred to as junior doctors in the study) appeared the least likely to engage in patient safety behaviors. Attending physicians (referred to as senior doctors in the study) were 1.5 times more likely than medical residents to exhibit patient safety behaviors, while experienced nurses (called senior nurses in the study) were six times more likely to exhibit these behaviors.

Compared to other study practitioners, medical residents were more likely to perceive blame as the result of an event, less likely to speak up when an error was made, and less likely to offer positive reports about management. The authors note that the existing culture in academic medicine, which nurtures individual autonomy and competitiveness rather than collaboration and openness, may explain some of the differences between medical residents and other professional groups.

It follows from these findings that the influence of credible clinical leaders who believe in, and are prepared to model, patient safety behaviors in the workplace is key.5 When it comes to patient safety, actions truly speak louder than words. The study results make it clear that peer-to-peer mentorship at the work unit and facility level, with specific roles in modeling patient safety behaviors, is needed to

### Table 1 Variables That Might Predict Patient Safety Behavioral Intent5

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<th>Variable</th>
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<td>Prior attendance at a human error/patient safety workshop</td>
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<td>Work satisfaction</td>
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<td>Belief in personal causes of errors (e.g., stress, fatigue)</td>
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<tr>
<td>Belief in system causes of errors (e.g., environment, system design)</td>
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<tr>
<td>Management responsiveness (e.g., provision of feedback, no blame)</td>
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<tr>
<td>Preventive action beliefs (beliefs that engaging in specific patient safety–related behaviors improves patient safety)</td>
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<tr>
<td>Hospital support for safety (e.g., providing staff education, mentoring, orientation)</td>
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<tr>
<td>Incident analysis (belief that management uses information to inform and prevent further events)</td>
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<tr>
<td>Professional peer behavior (perceptions regarding one’s own professional colleagues’ patient safety behaviors)</td>
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<tr>
<td>Belief in patient safety principles (e.g., standardization, redundancy, forcing functions, system redesign)</td>
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<tr>
<td>Belief in open disclosure (e.g., being open and honest with patients after an event)</td>
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provide guiding examples that encourage safe behavioral choices and foster a culture of safety within the organization. This includes physician-to-physician mentorship. If there is a visible commitment to safety within the organization that is evident in the behaviors of its members, it is more likely that safe work practices will be followed.8

So, always keep in mind that your professional peers are likely learning from your behaviors on a day-to-day basis, whether it involves taking a shortcut that is thought to be necessary at the time or speaking up about a risk you observe. Patient safety—indeed, a culture of safety—begins with you leading by example.

REFERENCES

9. Sexton JB. University of Texas Center of Excellence for Patient Safety Research and Practice. Technical Report 03-02 (AHRQ grant number 1PO1HS1154401 and U18HS1116401).